Sutter Specialty Services Referral Form

Sutter Health

(Required)

PATIENT

Name _____

DOB _____ SSN: _____

Address _____

City _____ State ____ Zip _____

Phone ( ) _____

Patient/Guarantor _____

PRIMARY CARE PHYSICIAN

Name _____

Address _____

City _____ State ____ Zip _____

REFERRING MD

Does your office have access to SutterLink/Sutter EHR
☐ Yes ☐ No

Name _____

Group Affiliation _____

Address _____

City _____ State ____ Zip _____

Phone ( ) _____

Fax ( ) _____

Main Contact Person ( ) _____

INSURANCE

Insurance Company _____

Phone ( ) _____

Authorization Number _____

Person Authorizing _____

Any conditions covered by CCS? ☐ Yes ☐ No

SPECIALTY REQUESTED

☐ ADULT ☐ PEDIATRIC

☐ Allergy/Immunology
☐ Cardiology
☐ Cardiovascular
☐ Colon/Rectal Surgery
☐ Dermatology
☐ Endocrinology
☐ Gastroenterology
☐ Hematology/Oncology
☐ Infectious Disease
☐ Maternal/Fetal Medicine
☐ Nephrology
☐ Neurology
☐ Neurosurgery
☐ Oncologic Surgery
☐ Orthopedics
☐ Ophthalmology
☐ Otolaryngology
☐ Plastic Surgery
☐ Pulmonology
☐ Reproductive Endocrinology
☐ Rheumatology
☐ Urology
☐ Vascular Surgery

☐ Other _____

Diagnosis

Clinical History

FAX FORM TO SUTTER SPECIALTY NETWORK AT (916) 503-7632 **1-888-834-1788** checksutterfirst.org/SSN